Reduced Benefits For Failure To Follow Required Review Procedures

When the required review procedures are followed, your benefits will be unaffected, and you and the plan avoid expenses related to unnecessary health care. However, if you do not follow the health care management procedures outlined above, expenses will not be considered for reimbursement.

The amount you pay when you do not comply with the health care management program's review procedures does not apply toward your out-of-pocket maximum.

MaterniHealth Program

The primary objective of MaterniHealth is to anticipate the possibility of a high or moderate risk pregnancy and coordinate cost effective medical care.

You should call the health care management program's toll-free number (1-800-648-4670) during the first trimester of pregnancy or upon confirmation of pregnancy. At this time, a Registered Nurse will ask you questions about your general health and medical history. This information will be discussed with your *physician* and will help determine the risk factor of your pregnancy.

If your pregnancy is classified as low risk, you will have satisfied the maternity precertification requirement. You only need to call again when you are admitted to the *hospital* for delivery. If your pregnancy is classified as moderate or high risk, the health care management program will follow your case, recommend specialists and/or facilities when applicable and coordinate communication among *health care providers*, patients and others.

Catastrophic Case Management

Catastrophic case management is designed to help manage the care of patients who have catastrophic or extended care *illnesses* or *injuries*.

The primary objective of catastrophic case management is to identify and coordinate cost effective medical care alternatives meeting accepted standards of medical practice. Catastrophic case management also monitors the care of the patient, offers emotional support to the family, and coordinates communications among *health care providers*, patients and others.

These objectives will be met through contractual benefits (and non-contractual benefits on an exception basis) to patients who are eligible and voluntarily agree to the alternate benefits plan.

Examples of *illnesses* or *injuries* that would be appropriate for catastrophic case management include, but are not limited to:

- Terminal *Illnesses*
  - cancer
  - AIDS
- Chronic *Illnesses*
  - multiple sclerosis
  - renal failure
  - obstructive pulmonary disease
  - cardiac conditions
- *Accident* Victims Requiring Long-Term Rehabilitative Therapy
- Newborns with High Risk Complications or Multiple Birth Defects
- Diagnosis Involving Long-Term IV Therapy
- *Illnesses* Not Responding to Medical Care
- Child and Adolescent Mental/Nervous Disorders

Hospital Bill Audit

The purpose of the *hospital* bill audit is to protect you and the plan from billing errors and unnecessary services. By reviewing these situations the plan can help assure you that the level of care and the services you received are compatible with the amount billed.

Hospital confinements in which the *hospital* billed charges are over the threshold amount will be evaluated to determine if an audit is necessary. In addition, *hospital* bills of less than the threshold amount will be pre-screened for billing irregularities and audited when appropriate.

MEDICAL BENEFITS

About Your Medical Benefits

All benefits provided under this plan must satisfy some basic conditions. The following conditions are commonly included in health benefit plans but are often overlooked or misunderstood.

Medical Necessity

The plan provides benefits only for covered services and supplies that are *medically necessary* for the treatment of a covered *illness* or *injury*. Also the treatment must be generally accepted by medical professionals in the United States and non-experimental.

Usual and Customary Charges

The plan provides benefits only for covered expenses that are equal to or less than the *usual and customary charge* in the geographic area where services or supplies are provided. Any amounts that exceed the *usual and customary charge* are not recognized by the plan for any purpose.

Health Care Providers

The plan provides benefits only for covered services and supplies rendered by a *physician*, *practitioner*, *nurse*, *hospital* or *specialized treatment facility* as those terms are specifically defined in the Definitions section.

Maintenance Care

The plan does not provide benefits for services and supplies intended primarily to maintain a level of physical or mental function.

Custodial Care

The plan does not provide benefits for services and supplies that are furnished primarily to assist an individual in the activities of daily living. Activities of daily living include such things as bathing, feeding, administration of oral medicines, or other services that can be provided by persons without the training of a *health care provider*.

Period of Confinement

The time during which a covered person is an *inpatient* in an approved facility. If the covered person is discharged and again readmitted, additional charges will be part of the original confinement unless you have returned to work for 1 day, or in the case of your dependents, 90 days have lapsed since the date of discharge. An admittance due to an entirely different cause will be considered to be a new *period of confinement*.

Benefit Year

The word *year*, as used in this document, refers to the *benefit year* which is the 12-month period beginning January 1 and ending December 31. All annual benefit maximums and deductibles accumulate during the *benefit year*.

Deductibles

A deductible is the amount of covered expenses you must pay during each *year* before the plan will consider expenses for reimbursement. The individual deductible applies separately to each covered person. The family deductible applies collectively to all covered persons in the same family. When the family deductible is satisfied, no further deductible will be applied for any covered family member during the remainder of that *year*.

The annual individual and family deductible amounts are shown on the Schedule of Medical Benefits.

Inpatient Hospital Deductible

An *inpatient hospital* deductible is the amount of covered *hospital* expenses you must pay in addition to the regular deductible amount. The *inpatient hospital* deductible applies to each *period of confinement*. The *inpatient hospital* deductible and any regular deductible must be satisfied before the plan will consider remaining covered expenses for reimbursement.

The *inpatient hospital* deductible amount is shown on the Schedule of Medical Benefits.

Common Accident Deductible

When 2 or more covered persons in your family are injured in the same *accident*, only one deductible must be met before the plan will consider benefits for expenses incurred as a result of the *accident*.

Co-Payments

Co-payment percentages represent the portions of covered expenses paid by you and by the plan after satisfaction of any applicable deductible. These percentages apply only to covered expenses which do not exceed *usual and customary charges*. You are responsible for all non-covered expenses and any amount which exceeds the *usual and customary charge* for covered expenses.

The co-payment percentages are shown on the Schedule of Medical Benefits.

Out-Of-Pocket Maximum

An out-of-pocket maximum is the maximum amount of covered expenses you must pay during a *year*, excluding the deductible, before the co-payment percentage of the plan increases. The individual out-of-pocket maximum applies separately to each covered person. When a covered person reaches their annual out-of-pocket maximum, the plan will pay 100% of additional covered expenses for that individual during the remainder of that *year*.

The family out-of-pocket maximum applies collectively to all covered persons in the same family. When the annual family out-of-pocket maximum is reached, the plan will pay 100% of covered expenses for any covered family member during the remainder of that *year*.

The annual individual and family out-of-pocket maximum amounts are shown on the Schedule of Medical Benefits.

Benefit Maximums

Total plan payments for each covered person are limited to certain maximum benefit amounts. A benefit maximum can apply to specific benefit categories or to all benefits. A benefit maximum amount also applies to a specific time period, such as annual or *lifetime*. Whenever the word *lifetime* appears in this plan in reference to benefit maximums, it refers to the time you or your dependents participate in this plan or any other plan sponsored by Sinclair Broadcast Group, Inc.

The benefit maximums applicable to this plan are shown on the Schedule of Medical Benefits.

Covered Medical Expenses

When all of the provisions of this plan are satisfied, the plan will provide benefits as outlined on the Schedule of Medical Benefits only for the services and supplies listed in this section.

Hospital Services

- Room and board, not to exceed the cost of a semi-private room or other accommodations if the attending *physician* certifies necessity. If a private room is the only accommodation available, the plan will cover an amount equal to the prevailing semi-private room rate in the geographic area.

- *Intensive care unit* and coronary care unit charges.

- Miscellaneous *hospital* services and supplies required for treatment during a *hospital* confinement.

- Well-baby nursery, *physician* and initial exam expenses during the initial *hospital* confinement of a newborn.

- *Hospital* confinement expenses for dental services if the attending *physician* certifies that hospitalization is necessary to safeguard the health of the patient.

Emergency Services

- Treatment in a *hospital* emergency room or other emergency care facility for a condition that can be classified as a *medical emergency*.

- Ground or air transportation provided by a professional ambulance service to the nearest *hospital* or emergency care facility equipped to treat a condition that can be classified as a *medical emergency*, within a 50-mile radius.

- Treatment of an *accident* in a *hospital* or other emergency care facility. Treatment must begin within 90 days of the *accident* unless a delay is *medically necessary*. The *accident* must have occurred while covered under this plan.

Specialized Treatment Facilities

- A *skilled nursing facility*, if confinement begins within 14 days of a *hospital* confinement of at least 3 days, limited to 120 days per *year*.

- A *mental/nervous treatment facility*.

- A *substance abuse treatment facility*.

- An *ambulatory surgical facility*.

- A *birthing center*.

- A *hospice facility* when the attending *physician* certifies that life expectancy is 6 months or less. Bereavement counseling is included for the immediate family, limited to 15 visits within 6 months of the patient's death.

Surgical Services

- Surgeon's expenses for the performance of a surgical procedure.

- Assistant surgeon's expenses not to exceed 25% of the *usual and customary charge* of the surgical procedure.

- Two or more surgical procedures performed during the same session through the same incision, natural body orifice or operative field. The amount eligible for consideration is the *usual and customary charge* of the largest amount billed for one procedure plus 50% of the sum of *usual and customary charges* billed for all other procedures performed.

- Two or more surgical procedures performed during the same session through different incisions, natural body orifices or operative fields. The amount eligible for consideration is the *usual and customary charge* for the largest amount billed for one procedure plus 50% of the sum of the *usual and customary charges* billed for all other procedures performed.

- Anesthetic services, when performed by a licensed anesthesiologist or certified registered nurse anesthetist in connection with a surgical procedure.

- Acupuncture for anesthetic purposes.

- *Oral surgery*, limited to removal of tumors and cysts; incision of sinuses, salivary glands or ducts; frenectomy; treatment of cleft lip and palate; extraction of partially or completely unerupted teeth; and treatment of an accidental *injury* to sound and natural teeth which occurred while covered under this plan.

- *Cosmetic surgery*, only when needed to correct damage caused by a birth defect resulting in the malformation or absence of a body part, an accidental *injury* or for breast reconstruction following a total or partial mastectomy. All eligible *illnesses* or *injuries* must have occurred while covered under this plan.

- Surgical reproductive sterilization.

- Circumcision.

- *Outpatient surgery*.

- Surgical treatment of temporomandibular joint dysfunction (TMJ).

- Podiatry *surgery*.

- Amniocentesis only when the attending *physician* certifies that the procedure is *medically necessary*.

Mental/Nervous And Substance Abuse Treatment

- *Inpatient* mental/nervous and substance abuse (drug and alcohol) treatment.
- *Outpatient* mental/nervous and substance abuse (drug and alcohol) treatment.
- Treatment of or related to eating disorders.

Medical Services

- *Physician* office visits.
- *Inpatient* visits by the attending *physician.*
- *Inpatient* visits by a non-attending *physician.*
- Required *second surgical opinions.*
- *Third surgical opinions.*
- Pregnancy related care.
- Treatment of *complications of pregnancy.*
- Termination of pregnancy.
- Dental services received after an accidental *injury* to sound and natural teeth. This includes replacement of such teeth and any related x-rays. Treatment must be received within 90 days of the *injury* unless a delay is *medically necessary.* The accidental *injury* must have occurred while covered under this plan.
- *Chiropractic services.*
- Radiation therapy.
- Chemotherapy.

- Physical therapy from a qualified *practitioner* and received under the direct supervision of the attending *physician.*

- Non-custodial services of a *nurse* which are not billed by a *home health care agency.*

- Home health care provided by a *home health care agency*, limited to 40 visits per *year.*

- *Home hospice* when the attending *physician* certifies that life expectancy is 6 months or less. Bereavement counseling is included for the immediate family, limited to 15 visits, within 6 months of the patient's death.

- Speech therapy from a qualified *practitioner* to restore normal speech loss due to an *illness, injury* or surgical procedure. The loss must have occurred while covered under the plan.

- Occupational therapy.

- Treatment of or related to sleep disorders.

- Initial consultation for the diagnosis of an eating disorder.

- Treatment of feet due to a metabolic or peripheral-vascular disease, if the attending *physician* certifies that the procedures are *medically necessary.*

Diagnostic X-Ray And Laboratory Services

- *Diagnostic charges* for x-rays.

- *Diagnostic charges* for laboratory services.

- Pre-admission testing (PAT).

- Genetic testing.

- Ultrasound.

- Allergy testing.

Routine And Preventative Services

- Mammograms, limited to 1 per *year*.
- PAP tests, including the exam.
- Physicals.
- Well-baby check-ups, including vaccinations, inoculations, or immunizations.

Equipment And Supplies

- *Durable medical equipment*, including expenses related to necessary repairs and maintenance. A statement is required from the prescribing *physician* describing how long the equipment is expected to be necessary. This statement will determine whether the equipment will be rented or purchased. Replacement equipment will be covered if the replacement equipment is required due to a change in the patient's physical condition; or, purchase of new equipment will be less expensive than repair of existing equipment.
- Artificial limbs and eyes.
- Original fitting, adjustment and placement of orthopedic braces, casts, splints, crutches, cervical collars, head halters, traction apparatus, or prosthetic appliances to replace lost body parts or to aid in their function when impaired.
- Oxygen and rental of equipment required for its use, not to exceed the purchase price of such equipment.
- Orthotics, orthopedic or corrective shoes and other supportive appliances for the feet.
- Blood and/or plasma, if not replaced, and the equipment for its administration.
- Insulin and insulin syringes.

- Insulin infusion pumps.

- Initial prescription contact lenses or eye glasses, including the examination and fitting of the lenses, to replace the human lens lost through intraocular *surgery* performed while covered under the plan.

- Occupational therapy supplies.

- Sterile surgical supplies after *surgery*.

- Jobst garments, limited to 2 per *year*.

Medical Expenses Not Covered

The plan will not provide benefits for any of the items listed in this section regardless of *medical necessity* or recommendation of a *health care provider*. This list is intended to give you a general description of expenses for services and supplies not covered by the plan.

- Expenses exceeding the *usual and customary charge* for the geographic area in which services are rendered.
- Expenses unnecessary for diagnosis of an *illness* or *injury*.
- Treatment not prescribed or recommended by a *health care provider*.
- Services, supplies or treatment not *medically necessary*.
- Services or supplies for which there is no legal obligation to pay, or expenses which would not be made except for the availability of benefits under this plan.
- Experimental equipment, services or supplies which have not been approved by the United States Department of Health and Human Services or the appropriate government agency.
- Complications arising from any non-covered *surgery* or treatment.
- Services furnished by or for the United States Government or any other government, unless payment is legally required.
- Any condition, disability or expense sustained as a result of being engaged in: an illegal occupation, commission or attempted commission of an assault or other illegal act, intentional or accidental atomic explosion or other release of nuclear energy, whether in peacetime or wartime, participation in a civil revolution or a riot, duty as a member of the armed forces of any state or country or a war or act of war which is declared or undeclared.

- Any condition or disability sustained as a result of being engaged in an activity primarily for wage, profit or gain, and that could entitle the covered person to a benefit under the Workers' Compensation Act or similar legislation.

- Educational, vocational or training services and supplies.

- Expenses for preparing medical reports, itemized bills, or claim forms.

- Mailing and/or shipping and handling expenses.

- Expenses for broken appointments or telephone calls.

- Services or supplies furnished, paid for, or for which benefits are provided or required by reason of past or present service of any covered family member in the armed forces of a government.

- Travel expenses of a *physician* or a covered person.

- Any services received from a Health Maintenance Organization (HMO) if the individual is a participant in the HMO.

- Intentional self-inflicted *injury* or *illness* while sane or insane.

- Professional services performed by a person who ordinarily resides in your household or is related to the covered person, such as a spouse, parent, child, brother, sister, or in-law.

- Sanitarium, rest or *custodial care*.

- Expenses used to satisfy plan deductibles.

- Expenses eligible for consideration under any other plan of the *employer*.

- Expenses incurred for services rendered prior to the effective date of coverage under this plan.

- Sales tax.

- Personal comfort or service items while confined in a *hospital*, such as, but not limited to, radio, television, telephone, and guest meals.

- *Elective hospital admissions* on Friday, Saturday or Sunday unless approved by the health care management program. If *surgery* is scheduled for Monday, Sunday admissions will be eligible for consideration.

- *Cosmetic surgery*, except as specified in Covered Medical Expenses.

- Human organ transplants. Coverage is provided under a separate policy. Contact your benefits office for more information.

- Expenses related to insertion or maintenance of an artificial heart.

- Sex change *surgery*.

- Penile prosthetic implant.

- Surgical treatment for the correction of infertility.

- Surgical impregnation procedures.

- Surgical treatment of *morbid obesity*.

- Reversal of any reproductive sterilization procedure.

- Kerato-refractive eye *surgery* (*surgery* to improve nearsightedness, farsightedness, and/or astigmatism by changing the shape of the cornea, including but not limited to radial keratotomy and keratomileusis *surgery*).

- Massage therapy or rolfing.

- Marital counseling.

- Family counseling.

- Sex counseling.

- Dental services or treatment, except as specified in Covered Medical Expenses.

- Expenses for education, counseling, job training or care for learning disorders or behavioral problems, whether or not services are rendered in a facility that also provides medical and/or mental/nervous treatment.

- Non-surgical treatment of *morbid obesity* and treatment, instructions, activities or drugs (including diet pills) for weight reduction or control, except as specified in Covered Medical Expenses.

- Eye examinations for the diagnosis or treatment of a refractive error, including the fitting of eyeglasses or lenses, orthoptics, vision therapy or supplies unless such treatment is due to a covered *illness* or accidental *injury*.

- Hearing examinations, hearing aids or related supplies, unless loss of hearing is due to a covered *illness* or accidental *injury*.

- Treatment of or related to an overdose of a drug or medication, unless the overdose was accidentally inflicted.

- Adoption expenses.

- Surrogate expenses.

- Expenses incurred for non-surgical treatment of the feet including treatment of corns, callouses and toenails, or other routine foot care, except as specified in Covered Medical Expenses.

- Non-surgical treatment for, or prevention of, temporomandibular joint dysfunction (TMJ) and craniomandibular disorder and other conditions of the joint linking the jawbone and skull, and the muscles, nerves and other tissues related to that joint.

- Non-surgical treatment for the correction of infertility.

- Biofeedback.
- Hypnosis.
- Genetic counseling.
- Infertility testing.
- Wigs and artificial hair pieces.
- Drugs, medicines, or supplies that do not require a *physician's* prescription.
- Expenses for infertility drugs, vitamins and nutritional supplements (including pre-natal vitamins) and drugs and devices for contraception regardless of whether or not a *physician's* prescription is required.
- Prescription drugs and medicines. Benefits are provided by APS.
- Equipment such as air conditioners, air purifiers, dehumidifiers, heating pads, hot water bottles, water beds, swimming pools, hot tubs and any other clothing or equipment which could be used in the absence of an *illness* or *injury*.
- Orthodontic treatment of cleft palate.

DENTAL BENEFITS

About Your Dental Benefits

All benefits under this plan must satisfy some basic conditions. The following conditions are commonly included in dental benefit plans but are often overlooked or misunderstood.

Alternate Procedure

The plan provides benefits only for the most cost effective treatment of a dental condition which provides a professionally acceptable result as determined by national standards of dental practice.

Pre-treatment Review

When a dental service is expected to exceed $200 your *dentist* should submit a proposed course of treatment prior to the actual performance of services. The proposed course of treatment includes a completed claim form itemizing all services and procedures and the charge for each procedure. Evaluation of the treatment is subject to *alternate procedure* and does not guarantee payment of benefits when the actual services are performed.

Usual and Customary Charges

The plan provides benefits only for covered expenses that are equal to or less than the *usual and customary charge* in the geographic area where services or supplies are provided. Any amount that exceeds the *usual and customary charge* is not recognized by the plan for any purpose.

Dental Care Providers

The plan provides benefits only for covered services rendered by a *dentist* or *dental hygienist* as those terms are specifically defined in the Definitions section.

Benefit Year

The word *year*, as used in this document, refers to the *benefit year* which is the 12-month period beginning January 1 and ending December 31. All annual benefit maximums and deductibles accumulate during the *benefit year*.

Deductibles

A deductible is the amount of covered expenses you must pay during each *year* before the plan will consider expenses for reimbursement. The individual deductible applies separately to each covered person. The family deductible applies collectively to all covered persons in the same family. When the family deductible is satisfied, no further deductible will be applied for any covered family member during the remainder of that *year*.

The annual individual and family deductible amounts are shown on the Schedule of Dental Benefits.

Co-Payments

Co-payment percentages represent the portions of covered expenses paid by you and by the plan after satisfaction of any applicable deductible. These percentages apply only to covered expenses which do not exceed *usual and customary charges*. You are responsible for all non-covered expenses and any amount which exceeds the *usual and customary charge* for covered expenses.

The co-payment percentages are shown on the Schedule of Dental Benefits.

Benefit Maximums

Total plan payments for each covered person are limited to certain maximum benefit amounts. A benefit maximum can apply to specific benefit categories or to all benefits. A benefit maximum also applies to a specific time period, such as annual or *lifetime*. Whenever the word *lifetime* appears in this plan in reference to benefit maximums, it refers to the period of time you or your dependents participate in this plan or any other plan sponsored by Sinclair Broadcast Group, Inc.

The benefit maximums applicable to this plan are shown on the Schedule of Dental Benefits.

Covered Preventative Services

The plan will provide benefits as outlined on the Schedule of Dental Benefits for expenses considered preventative services according to all provisions, requirements and limitations of the plan.

- Oral examination, limited to once in a period of 6 months.
- Prophylaxis (cleaning of the teeth), limited to once in a period of 6 months.
- Examination for consultation purposes.
- Bite-wing x-rays, limited to once in a period of 6 months.
- Full mouth x-rays, limited to once in a period of 36 months.
- Other x-rays, including occlusal, cephalometric, panoramic and periapical x-rays, necessary to diagnose a dental condition.
- Topical application of sodium or stannous fluoride for children under age 19.
- Application of sealants on posterior teeth (molars) for children under age 19.
- Space maintainers.

Covered Basic Services

The plan will provide benefits as outlined on the Schedule of Dental Benefits for expenses considered basic services according to all provisions, requirements and limitations of the plan.

- Examination in connection with emergency palliative treatment.
- Injections of antibiotic drugs by the attending *dentist*.
- Local anesthesia.

- Tooth extractions, except for impactions.
- *Oral surgery*, including surgical extractions.
- Administration of *general anesthesia* in connection with *oral surgery*.
- Amalgam, silicate, acrylic, synthetic porcelain and composite filling restoration for decayed teeth.
- Endodontic treatment.
- Harmful habit appliances.
- Repair and recementing of inlays and onlays.

Covered Major Services

The plan will provide benefits as outlined on the Schedule of Dental Benefits for expenses considered major services according to all provisions, requirements and limitations of the plan.

- Gold restorations.
- Treatment of periodontal and other diseases of the gums and supporting structures of the mouth.
- Installation of crowns, bridges, or partials.
- Initial installation of dentures.
- Inlays and onlays.
- Crowns, including post and core or crown buildup when there is insufficient tooth structure to hold the crown.
- Repair or recementing of crowns.
- Adjusting, relining or rebasing of dentures.

- Initial installation of fixed bridgework (including wing attachments, inlays and crowns as abutments) to replace natural teeth which were extracted while covered under this plan.

- Replacement of an existing partial or full removable denture or fixed bridgework; the addition of teeth to an existing partial or removable denture; or, bridgework to replace teeth which were extracted if satisfactory evidence is presented to the plan that:

  The addition of teeth is necessary to replace one or more teeth extracted after the existing denture or bridgework was installed and while a participant in the plan.

  The existing denture or bridgework cannot be made serviceable and was installed at least 5 years prior to the replacement date.

  The existing denture is an immediate temporary denture replacing one or more natural teeth extracted while participating in the plan, replacement by a permanent denture is required, and the replacement takes place within 12 months from the placement of the temporary denture.

- Periodontal appliances.

- Occlusal adjustment.